Chapter Four

Optical Services

Overview

Introduction

This chapter gives provides guidelines for providing optical services for Medicaid eligible recipients.

In This Chapter

This chapter contains:

Vision Care Services

What are Vision Care Services?

Vision care services are exams, materials, and services related to the provision of visual aids by ophthamologists, optometrists, and opticians within the scope of their practice as defined by North Carolina State Laws (NCGS 90-127.3 and NCAC 42E).

Conditions of Participation

All providers participating in the N.C. Medicaid program must meet the following conditions of participation and adhere to regulations and guidelines as they relate to the services rendered:

- If the provider is not going to perform the eye exam **and** provide glasses, the provider must inform the recipient prior to services being offered. The recipient must be given the option to select a provider who will provide both services.

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Vision Care Services, Continued

Conditions of Participation (continued)

- If the recipient elects to have the examination, a written prescription for the visual aids must be given or offered to the recipient at the time of the examination. The prescriber cannot withhold the prescription pending Medicaid payment for the refraction.
- If the recipient is not satisfied with the frame selection or services, the provider must allow the recipient the freedom of choice and give the recipient the prescription for the glasses prior to ordering the eyeglasses or the fabrication of the eyeglasses.

Recipient Eligibility

Who is Eligible for Optical Services?

Providers must be aware that eye care services may be limited or not covered in some of the Medicaid programs. It is the provider's responsibility to verify the recipient's eligibility. Retain a copy of the recipient's Medicaid identification (MID) card that corresponds to the date of service. The recipient can be identified by the following MID cards:

Blue MID Card – Medicaid	Eye refractions and visual aids are covered. Prior approval is required for visual aids.
Blue MID Card – HMO	HMO is printed on the blue MID card. These services are covered in plan and are billed to the HMO directly.
Blue Card – Carolina ACCESS	Medicaid recipients who are enrolled in the Carolina ACCESS program are not required to obtain their primary care physician's approval for an eye care provider to perform an eye refraction and supply glasses. These services are subject to all Medicaid guidelines, limitation, and prior approval criteria.
Pink MID Card – MPW (Pregnant Women)	Pregnant women eligible for MPW benefits are not covered for routine eye care or eye glasses. Special consideration can be given to recipients referred by a medical doctor due to complications of pregnancy. For special consideration, submit a general Request for Prior Approval form (372-118) with the following information to be reviewed by the EDS medical director: • blood sugar • blood pressure • hemoglobin • protein in urine (if any) • weeks gestation Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118).

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Recipient Eligibility, Continued

Who is Eligible for Optical Services? (continued)

Pink MID Card – HMO	Pregnant women eligible for MPW benefits are not covered for routine eye care or eye glasses. However, special consideration can be given to for conditions that are due to complications of pregnancy. Contact the HMO listed on the recipient's current Medicaid card.
Pink MID Card – Carolina ACCESS	Pregnant women eligible for MPW benefits are not covered for routine eye care or eye glasses. However, special consideration can be given to for conditions that are due to complications of pregnancy. If a service requires prior approval, submit a general Request for Prior Approval form (372-118) with the following information to be reviewed by the EDS medical director: • blood sugar • blood pressure • hemoglobin • protein in urine (if any) • weeks gestation Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118).
Buff MID Card – MQB	Medicare Qualified Beneficiary (MQB) – No payment of straight Medicaid claims is allowed. Medicare does not cover eye refractions or nonaphakic visual aids. Therefore, these services are noncovered by Medicaid for MQB recipients. Copayment and deductibles for Medicare-covered services will crossover to Medicaid for payment. Advise MQB recipients that they will be responsible for payment of the refraction and nonaphakic visual aids before performing the services.

Denied Claims Due to Recipient Ineligibility on Date of Service

Dispensing claims for recipients whose eligibility was terminated in the month following the date of the eye refraction can be resubmitted with the refraction date as the date of service if the following criteria is met:

1. The approval date is within three months of the prescription date.
2. The recipient is eligible for Medicaid on the date of the refraction but is not eligible on the date the glasses were dispensed.

Providers must enter the refraction date as the date of service in block 24A on the HCFA-1500 claim form. (Retroactive prior approval will only be granted for the previous three-month period.)

Claims for repairs or replacement should document the actual date of authorization or date of dispensing as the date of service. The provider must verify eligibility prior to requesting the repair or replacement. If the recipient's eligibility has ended when the new or repaired glasses are dispensed, providers can use the date that the repair or replacement request was initiated. Refer to *Claims Submission and Billing* for more information.

Routine Eye Examinations and Refractions

Time Limits

Routine eye examinations with a refraction are limited to once per year for recipients under 25 years of age and once every two years for recipients 25 years of age and older.

Medicare/ Medicaid Patients

If a recipient has Medicare and there is no medical diagnosis, the provider needs to follow the Medicare guidelines when billing Medicare. However, Medicare does not cover refractions. If the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copay will be deducted for services not covered by Medicare unless the recipient qualifies for specific copay exemptions.

Cataract Patients

Yearly evaluations for visual checks and cataract development should be billed as a brief office visit. These services do not require prior approval or a complete exam or refraction. If acuity is diminished to the point of needing a change in lens power (generally equal to or greater than one diopter), the provider must submit a written general Request for Prior Approval form (372-118) for the second refraction. After receiving approval for the refraction, the provider should request a visual aids prior approval for the lens change.

This request must include information stating that the recipient has cataracts and current **corrected** visual acuities (OC, OS, and OU).

Medicaid will not cover new lenses if the recipient is scheduled for cataract surgery. If new lenses are requested, document on the form that "recipient is not a candidate for cataract surgery."

Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118).

Eye Injuries

If a recipient requests an eye refraction at the time of an eye injury or if there is a condition present that could affect acuity (conjunctivitis, blepharitis, etc.), the refraction must be deferred until the problem is resolved and acuity is not affected. The provider bills the initial visit as an intermediate or limited visit, and when the refraction is performed at a later date, the "refraction only" CPT code 92015 is billed.

Diabetic Patients

Diabetic recipients do not generally require more frequent eye refractions or eyeglass lens changes than other recipients. However, retinal disease (diabetic retinopathy, macular degeneration, etc.) is the leading cause of blindness in diabetic patients. Therefore, it is important that diabetic recipients are seen annually to evaluate the health of the eye. For recipients with no complications, providers should bill for an office visit a minimum of one year after the previous eye exam date. Based on the findings, more frequent evaluation may be indicated.

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Routine Eye Examinations and Refractions, Continued

Diabetic Patients (continued)

Providers should bill one of the following CPT codes and follow CPT guidelines:

Office Visit – New Patient (No prior authorization required)	Office Visit – Established Patient (No prior authorization required)
99201	99211
99202	99212
99203	99213
99204	99214
99205	

When a diabetic patient is evaluated for retinopathy, documentation of the evaluation should be forwarded to the primary care physician or referring physician.

If a significant change in visual acuity is detected during an office visit, the recipient should be referred back to the physician for evaluation of the diabetic condition (stable or unstable). The physician should write a referral to the ophthalmologist or optometrist stating the diabetic condition and requesting a new eye refraction. If the condition is stable, the optical provider may request a **refraction only** by submitting a general Request for Prior Approval form (372-118) and the referring physicians letter. Document medical justification for an early refraction in block 7 (i.e., visual acuity with current glasses, pressure changes, current medications, etc.). Each request for an early refraction will be reviewed on a case-by-case basis. A minimal change of one diopter of power is required for approval of new lenses.

If there has been significant change in the recipient's eyeglass prescription, the provider should request a Request for Prior Approval for Visual Aids form (372-107) for the lens change. This request must include information stating that the recipient has diabetes and current **corrected** visual acuities (OD, OS, or OU).

Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118) and to Attachment B for a copy of the Request for Prior Approval for Visual Aids form (372-107).

Prior Approval for Routine Eye Exams and Refractions

Requirements for Prior Approval

Eye refractions do not require prior approval. However, it is in the best interest of the provider to obtain an authorization. The 14-digit authorization number is for the provider's records. It is **not** necessary to enter the authorization number in block 23 of the HCFA-1500 claim form.

Authorization numbers can be obtained by calling the Automated Voice Response (AVR) system. (See Appendix B for the AVR telephone number.) Refer to the June 1999 Special Bulletin for additional information on the AVR system.

Prior Approval for Routine Eye Exams and Refractions, Continued

Claim Payments

When a provider with authorization and a provider without authorization bills for services within the same restricted time period, only the authorized provider's claim will process and will be allowed payment. **Prior approval does not guarantee payment**.

Restrictions on Obtaining Prior Approval through the AVR System

Prior approvals **cannot** be obtained by telephone through the AVR system if:

- the state eligibility file does **not** reflect current eligibility information,
- the recipient has a history of a paid eye refraction less than one year ago (under age 25) or less than two year ago (age 25 of over),
- the AVR system is down and eligibility cannot be verified (providers are instructed to call back),
- the recipient has a notice of eligibility approval from their county department of social services (DSS) but eligibility is not yet showing on the state eligibility file,
- the recipient is an HMO enrollee, or
- the recipient is eligible only for limited Medicaid coverage: pregnant women (MPW – pink card) or qualified Medicare beneficiary (MQB – buff card).

Requesting a Second Refraction Within the Time Limitation Period

A second refraction request within the time limitation period must be submitted on the general Request for Prior Approval form (372-118) documenting the medical necessity for a second refraction (loss of vision, significant decrease in acuity, eye injury, retinal or muscle surgery, etc.). Attach any additional documentation obtained from physicians, school nurses, Department of Motor Vehicles, etc.

Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118).

Completing the General Request for Prior Approval Form

Instructions for completing the prior approval form are listed below. **Note**: Use the same **provider name** and **number** on the HCFA-1500 claim form as is used on the prior approval form for dispensing services.

Refer to Attachment A for a copy of the general Request for Prior Approval form (372-118).

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Prior Approval for Routine Eye Exams and Refractions, Continued

Block	Field Name	Description
1	Prior Authorization Number	For EDS use only. Do not enter anything in this box.
2	Patient Name	Enter the patient's name as it appears on the MID card.
3	Medicaid ID Number	Enter the patient's 10-charcter MID number, which is found on the MID card. (The MID number is a 9-digit number followed by an alpha character.)
4	Date of Birth	Enter the patient's date of birth in MMDDYY format.
5	Diagnosis	If known, enter the patient's diagnosis.
6	ICD-9	Enter the ICD-9 code from the 6th edition of the 9th revision of the ICD-9 manual. Check the appropriate box for the type of request.
7	Brief Summary of Clinical Finding	If applicable, enter the clinical findings that substantiate request for service.
8/9	Retroactive Date(s) Requested (From/To)	If applicable, enter retroactive dates for service.
10	Procedure to be Performed	Enter description of requested procedure.
11	Procedure Code	Enter the procedure code, if applicable.
12	Reason Procedure in Necessary to the Patient's Health	Enter information substantiating medical necessity for requested service.
13	Has Patient Been Previously Provided with this Service	Indicate Yes or No.
13a	If Yes, Give Date Previous Service Rendered	Enter date(s) service rendered.
13b	Give Dates of Previous Prior Approval(s) Granted	Enter previous prior approval date(s) for this service.
14	Signature	Provider's signature required.
15	Provider's Number	Enter the provider's 7-digit Medicaid provider number, which is printed on the top left-hand corner of the Remittance and Status Advice.
16	Date	Enter the date the form was completed in MMDDYY format.
17	Place of Service	Enter the appropriate place of service code from the listing on the back of the form.
18	Provider's Name and Address	Enter the provider's name, street address, city, state, and zip code.

Billing Guidelines for Eye Exams with Refractions

Billing for Eye Exams with Refractions

When billing a refraction code (92004 – new patient exam with a refraction; 92014 – established patient exam with a refraction; 92015 – refraction only) providers should remember to use a refractive diagnosis as the primary diagnosis code. If a medical diagnosis is used (glaucoma, diabetic retinopathy, etc.), the refraction will be denied. One of the following diagnosis codes must be the primary diagnosis code for payment of the refraction:

Refer to *Claims Submission and Billing* for more information.

366.0	Cataract	367.8	Other disorders of refraction and accommodation
366.1	Cataract		
366.2	Cataract	367.9	Unspecified disorders of refraction and accommodation
366.3	Cataract		
366.4	Cataract	369.0	Low vision – blindness
366.5	After cataract	369.1	Low vision – blindness
366.8	After cataract	369.2	Low vision – blindness
366.9	After cataract	369.3	Low vision – blindness
367.0	Hyperopia	369.4	Low vision – blindness
367.1	Myopia	369.6	Low vision – blindness
367.2	Astigmatism	369.7	Low vision – blindness
367.3	Anisometropia/Aniseikonia	369.8	Low vision – blindness
367.4	Presbyopia	369.9	Low vision – blindness
367.5	Disorders or accommodation	V72.0	Routine eye and vision examination (glasses not prescribed)

Visual Aids

Covered Services

Visual aids are covered for all eligible Medicaid recipients based on age, medical necessity, and the restrictions listed below. Prior approval must be obtained for all visual aids using the Request for Prior Approval for Visual Aids form (372-017).

Refer to Attachment B for a copy of the Request for Prior Approval for Visual Aids form (372-017).

Restrictions

Visual aids are limited to once a year for recipients under 25 years of age and once every two years for recipients 25 years of age and older. When justified by medical necessity, the provider may request prior approval for a second refraction. A change in lens power generally equal to or greater than one diopter in either eye (progressive myopia, cataract development, etc.) may justify approval for new lenses.

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Visual Aids, Continued

Restrictions (continued)

Replacement of lost, stolen, or damaged visual aids may be considered when the prior approval form is accompanied by a DSS case manager's written recommendation for replacement. If visual aids are stolen, the prior approval request should also be accompanied by a police report. If visual aids are damaged in fire, the prior approval request should be accompanied by a fire report. If visual aids are damaged or lost due to an automobile accident, the prior approval request should be accompanied by the accident/police report.

All damaged frames less than one year old (from date of approval by EDS) should be evaluated for warranty coverage (see *Medicaid Frame Warranty*). If the frame is not under warranty through Nash Optical, document the cause and the extent of the damage in block 15 of the HCFA-1500 claim form and state that the frame is not covered by warranty. Prior approval requests for replacement frames that do not contain the frame evaluation information and warranty status will be returned to the provider for completion.

All requests and documentation will be carefully reviewed by a prior approval specialist. Approval will be granted or denied based on medical necessity, frequency of other replacements, and lens power.

Guidelines for Medicare/ Medicaid Visual Aids

Medicare covers only one pair of contact lenses or eyeglasses after cataract surgery with the insertion of an intraocular lens (per eye). Medicare will make no additional payment for replacement glasses or contact lenses. Claims for Medicaid-eligible recipients will crossover to Medicaid for payment of coinsurance and deductible. If only one eye requires a postcataract correction, the provider may request prior approval for that lens to be supplied through the provider's private or wholesale lab. When approved, the provider can file a Medicaid claim for the nonaphakic lens only (attach invoice) and use code V0730 and the dispensing code for one lens only.

Medicare will continue to cover frames and lenses for postcataract surgery without intraocular implants subject to program limitation. The copayment and deductible will crossover to Medicaid for payment. Medicaid must have the recipient's Medicare number on the crossover file, and the provider must be set up for crossover in the Medicaid system.

Frames

The Medicaid state contractor supplies frames. The contractor supplies zylonite combination, and metal frames for eligible Medicaid recipients. It is recommended that all providers are required to have a complete Medicaid fitting kit consisting of frames in available sizes and colors.

For a list of Medicaid frames and instructions for obtaining a fitting frame kit, providers must contact Nash Optical at 1-888-388-1353.

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Visual Aids, Continued

Medicaid Frame Warranty

Medicaid frames carry a one-year warranty from the original approval date. The warranty covers manufacturing defects and breakage or damage incurred during normal wear. To replace a frame covered under the warranty, call Nash Optical at 1-888-388-1353 with the frame information and description of the problem. Lab staff will check replacement frame availability. Prior approval is not required for warranty replacements.

Replacement Frame

In-stock: Ship the defective or damaged frame to the contractor lab. Upon receipt of the defective frame, the contractor lab will ship the replacement frame within 24 hours.

Out-of-stock: The contractor lab will provide instructions as to when the defective or damaged frame should be shipped.

If the contractor lab receives a damaged frame in which abuse or neglect is evident, the frame will be forwarded to the Division of Medical Assistance (DMA) for evaluation and follow-up with the provider.

Nonstandard Frames

Requests for a frame other than the frames available from the Medicaid contractor will be considered on an individual basis. Documentation of medical necessity for an exceptional frame must accompany the prior approval request or be documented in block 15 of the Request for Prior Approval for Visual Aids form (372-017). If a recipient cannot wear a frame from the Medicaid selection, identify the nonstandard frame requested (manufacturer, number or style, sizes, and wholesale cost of the frame).

Rimless frames will not be approved. The addition of nosepads on a Medicaid zylonite frame may be approved if no contract frame will fit the patient. Document medical necessity for "added" nosepads.

Recipient Purchase of Non-Medicaid Frame

A recipient **cannot** elect to purchase their own frame in lieu of a Medicaid frame. If the recipient elects to purchase a new frame not included in the Medicaid selection, the recipient will also be responsible for the purchase of lenses. This complete pair of eyeglasses will be a private transaction between the provider and the recipient. This private transaction in no way negates eligibility for Medicaid glasses. **Do not bill Medicaid.**

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Visual Aids, Continued

Lenses

Lenses are available in glass or plastic.

Single Vision	Lenses must be + or - .62 diopters or greater in either eye: sphere, cylinder, or prism. Prescriptions requiring less than .62 diopters can be evaluated by a consultant for children with documented insufficient accommodation. Approval or denial of these requests will be based on supporting documentation and medical necessity.
Bifocal	Lenses must have an add of +1.00 or greater and are available in CFR, FT-25, and FT-28.
Trifocal	Lenses are available in 7x25 and 7x28 and require justification of medical necessity.
Exceptions	FT-35 and executive lenses require documentation or justification for approval; young children, students, and recipients who require a wider field of vision (type of employment, etc.).

Cataract Lenses

Lenticular and lenticular aspheric lenses are covered subject to eligibility and time limitations.

Single Vision	Lenticular-Aspheric Aspheric, Full Field, *Super-Modular, Hyper-Aspheric
Bifocal	Round Seg Lenticular-Aspheric Aspheric Round, Hyper-Aspheric Round, *****Super Modular Round
Bifocal	Straight Top Lenticular-Aspheric ST Hyper-Aspheric ST, Full Field

*****Super-Modular lenses are available in Single Vision and Round Seg only. Straight top is **not** available.

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Visual Aids, Continued

Exceptional Lenses

Medicaid may approve the following lenses with documentation of medical necessity:

Oversize Lenses	Size 55 or over must be medically justified. Large bone structure, wide PD, broad face, etc. This applies to frames as well. **Reminder:** Oversize lenses cannot be approved for a recipient's own frame, if an oversize frame is not medically necessary or justified. The recipient's own frame must be identified in section 15 of the Request for Prior Approval for Visual Aids form (372-017) by frame name, manufacturer, and eye size.
Hi-Index (glass)	Based on lens power (+ or - 8.00 or higher); SV - 1.7 and 1.8 only; bifocal 1.7 only.
Polycarb/Hi-Index (plastic)	Single vision or bifocal (+ or 8.00 or higher) Current criteria for approval: • Patient is blind, or legally blind, with correction in one eye • Infants and toddlers (up to age 6) • Medical/physical conditions that result in frequent trauma or falls • When submitting a request for polycarbonate lenses, document the medical necessity (problem), in section 15 of the Request for Prior Approval for Visual Aids form (372-017).
Cosmolite (CR-39 plastic)	(+ 8.00 to + 10.00 only) Single vision of bifocal (+ 8.00 to 10.00 only)

Other services require documentation of medical necessity for approval: Myodisc, Press-on Prism, Special Base Curves, Slab-off, etc.

Nonauthorized Lenses for Frame

Medicaid cannot authorize lenses for the following frames:

- nonopthalmic frames (sunglasses, wrap-around, cosmetic, etc.)
- rimless frames requiring grooving, drilling or beveling
- lenses requiring special edging services for a non-Medicaid frame

Do not ask the visual aids contractor to supply materials or services prohibited by their contractual agreement with DMA.

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Visual Aids, Continued

Tints

The Medicaid contractor lab will only provide services (tints, photogray, etc.) approved by DMA or EDS. The contractor is not authorized to bill providers for noncovered services such as coverage for nonapproved photogray extra or hard coat. A recipient may elect to purchase a tint or UV supplied by the provider. The provider may bill the service to the recipient as a private transaction.

Tints	Pink #1, Pink #2, Gray #1, and Gray #2 may be covered by Medicaid for a documented diagnosis that induces photophobia: aphakia, albinism, etc.
Photogray	May be covered by Medicaid for a documented diagnosis that induces photophobia: aphakia, albinism, etc.
UV, Solid	Tints will be approved for aphakic patients requiring cataract lenses.
Other	Requests for tints (other than the above diagnoses) must be medically justified for consideration.

Special Circumstances

In special circumstances, uncut lenses may be ordered from the Medicaid contractor lab for edging in the provider's office. The provider should inspect the lens prescription and check the lens for scratches or defects **before** beginning the edging process. If a flaw is found in a lens, it should be returned to the contractor laboratory at no charge to the provider prior to edging. In the event of an error during edging, the provider assumes responsibility for the lens. The provider should bill from the following list:

Y5534	Supply uncut lenses (one or two); bill one unit at invoice cost. Attach wholesale supplier's invoice to the claim for payment.
Y5535	Edge and mount single vision lenses; per lens. Bill one lens as one unit. Bill two lenses as two units.
Y5536	Edge and mount multifocal lenses; per lens. Bill one lens as one unit. Bill two lenses as two units.

If the provider receives approval to supply lenses from an outside wholesale lab, the provider should bill V0730 (one unit) at invoice cost and attach a copy of the supplier's invoice to the Medicaid claim form. The invoice must identify the outside laboratory's name, address, telephone number, and invoice number. Invoices are verified for appropriate billing. Deduct any shipping (postage) or insurance charges, nonapproved tints, etc. These charges are not reimbursed by Medicaid. **Do not mail the recipient's frame to EDS or DMA** with the prior approval request. Neither the optical contractor, EDS, nor DMA can assume responsibility for the recipient's frame. The recipient's frame must be identified on the prior approval form by manufacturer, style name or number, sizes, and color.

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Visual Aids, Continued

Contact Lens

Requests will be evaluated for approval based on documentation of medical diagnoses and necessity: anisometropia, aphakia (without IOL), keratoconus, progressive myopia, etc.

Reimbursement fees for dispensing contact lenses include K-readings, measurements, fitting, trial lens (if required), patient education, and dispensing. The fee also includes follow-up care (training, etc.) for a six-month period.

An invoice must accompany a claim for the contact lens. One care kit (V2599) is covered for approved contact lenses.

Extended wear and disposable contact lenses are not covered by Medicaid.

Back-up Glasses

When contact lenses are deemed medically necessary, back-up glasses may be obtained through the Medicaid Visual Services program. Medically necessary contact lenses and back-up glasses for the same recipient require the following:

- Request for contact lenses and back-up glasses must be submitted on separate prior approval forms.
- In block 15 of the prior approval form, indicate that the request is for "back-up glasses."

Noncovered Services

Visual aids and services not covered by Medicaid include the following.

- Ocular prosthesis (artificial eye).
- Rimless frames or lenses for rimless frames.
- Safety glasses.
- Extended wear or disposable contact lenses.
- Contact lens supplies.
  Exception: if contact lenses have been approved by Medicaid, an initial care kit will be approved. Additional care kits are not covered.
- Gradient tints, sunglasses; any tint not medically justified by diagnosis.
- Sport straps, chains, etc.
- Affixing initials or engraving initials, name, etc. (frame or lenses).
- Hand-held magnifiers or any visual aid that can be purchased without prescription.
- Repairs costing less than $4.00.
- Transitions, blended or progressive bifocals.
- Visual training therapy and training devices.

Note: This list is not all-inclusive. Requests for special services not listed are considered on an individual basis.

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Visual Aids, Continued

Contractor Errors

All visual aids received from the contractor must be verified by the provider prior to dispensing glasses to a Medicaid recipient.

If the lenses are unacceptable due to poor edging, flaws, scratches, incorrect power, misaligned axis, or incorrect tinting, the provider should return the glasses to the contractor for a remake at no charge to the provider or to Medicaid. Contractor errors should be received at the Medicaid contractor laboratory within 45 days of the contractor's original shipping date. If incorrect lenses are not returned to the contractor within this time frame, the provider assumes responsibility for any necessary correction or remake.

If the frame is damaged, wrong color or size, wrong temple length, etc., the provider should contact the contractor and request a new frame and return the order for a frame replacement at no charge. If the frame is the wrong size or style, the frame must be returned to the contractor. The contractor will then be obligated to furnish new lenses. Contractor errors are not billed to Medicaid or to the provider and require "priority" expediting. If the contractor agrees to immediately ship the replacement front, temples, etc., the provider should then mail the defective or wrong size frame or part to the contractor as soon as possible.

All contractor errors should be returned to the contractor at no cost to the provider. The provider should call the contractor to request delivery arrangements for the return of the error to the contractor. The contractor will provide either a prepaid mailing label or schedule a pick-up by a shipping service (i.e., RPS, UPS, FedEx, etc.) to be charged to the contractor's shipping service account.

If a provider receives an order for a Medicaid recipient who is not their patient and the provider did not order the glasses, the provider should telephone the contractor immediately and return the glasses to the contractor as soon as possible.

If a duplicate pair of glasses is received from the contractor, return the second pair to the contractor. This may occur when the contractor cannot locate (track) the order in the process (upon request from the provider or DMA) and is required to start the process over again. Neither the provider nor DMA will be charged for this duplication. If an order is not received within 20 days after shipment, the contractor is required to duplicate the order at no charge to Medicaid or the provider.

Provider Errors

If there is a provider error and the contractor supplies the glasses as ordered by the provider on the prior approval form, the provider is responsible for absorbing the cost of the remake. Examples are transcribing or transposing the lens prescription, incorrect fitting measurements, improper frame fit, etc.

If there is a professional error regarding the lens prescription that necessitates a doctor's change in the prescription, the prescribing doctor is responsible for absorbing the cost of the lens remake.

- Remakes fabricated at the provider's cost may not be ordered from the Medicaid contractor lab.
- Do not bill Medicaid for provider error remakes.

Prior Approval for Visual Aids

Requirements for Prior Approval

Prior approval is required for all visual aids. The EDS Prior Approval unit reviews each request for prior services, medical justification, necessity, age, and other criteria before approving or denying the request. All requests for visual aids are reviewed by the EDS medical director and DMA. Prior approval does not negate the requirement of obtaining authorization from the recipient's primary care physician.

Restrictions on Obtaining Prior Approval

A visual aid prior approval number will **not** be issued if:

- the state eligibility file does not show current eligibility on the date of the review or the date of refraction,
- the recipient has MQB coverage,
- the recipient has MPW coverage, except in special circumstances due to complications of pregnancy, or
- the recipient has Medicaid HMO coverage (because the claims are billed directly to the HMO).

Instructions for Completing the Prior Approval for Visual Aids Form

Instructions for completing the Request for Prior Approval for Visual Aids form (372-017) are listed below. **Note**: Use the same provider name and number on the HCFA-1500 claim form as is used on the prior approval form for dispensing services.

Refer to Attachment B for a copy of the Request for Prior Approval for Visual Aids form (372-017).

Block	Field Name	Description
1	Patient Name - Last	Enter the patient's last name as it appears on the MID card.
2	Patient Name - First	Enter the patient's first name as it appears on the MID card.
3	Patient Name - MI	Enter the patient's middle initial as it appears on the MID card.
4	Sex	Enter the patient's gender (M for male or F for female).
5	Medicaid ID Number	Enter the patient's 10-charcter MID number, which is found on the MID card. (The MID number is a 9-digit number followed by an alpha character.)
6	Action (For Dept. Use Only)	Required information for contractors to process providers requests or orders: • For EDS prior authorization action only
7	Prior Authorization Number	Required information for contractors to process providers requests or orders: • For EDS prior authorization action only
8	Date of Birth	Enter the patient's date of birth in MMDDYY format.
9	Child Screening Referral	Not required.
10	Diagnosis	Enter the patient's diagnosis.
11	Date of Refraction	Enter the date of the most recent refraction.
12	Name of Prescriber	Enter the name of the prescriber.
13	Authorization Requested For	Enter the visual aids that are requested. * Indicates services which require documentation of medical necessity.

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Prior Approval for Visual Aids, Continued

Instructions for Completing the Prior Approval for Visual Aids Form, continued

Block	Field Name	Description
14	Last Prescription	Enter the last prescription for the patient if available.
15	Provider Documentation/ Justification for Approval	Block 15 is not required if approval for special services is not requested.
16	Please Circle One	Required information for EDS review of prior approval requests: • Lens prescription, bifocal type, PDs, seg heights, and Medicaid frame, name, and eye size. Frame information is also required when requesting "lenses only" for a recipient's own frame. Required information for contractors to process providers requests or orders: • Circle glass or plastic, tint, lens type: single vision, type of bifocal (CFR ST-25, 28), cataract lens type. Circle FT-35, executive or trifocal lenses when medical necessity is justified. If exceptional lenses have not been approved by EDS, the contractor cannot supply them. • Include complete frame description: color, eye size, bridge size, and temple lengths. If temple lengths are not designated, the contractor will supply the standard temple length. • If the patient's own frame is used, identify frame manufacturer, style, or number (zyl metal, other), color, and sizes.
17	Provider Authorization	This field is no longer being used.
18	Provider's Name, Address, and Number	Enter the provider's name, street address, city, state, and zip code. Enter the provider's 7-digit Medicaid provider number, which is printed on the top left-hand corner of the Remittance and Status Advice.
19	Signature	Provider's signature required.
20	Bill Date Telephone Number	Enter the date in MMDDYY format that the prior approval form was completed and a telephone number where the provider can be reached.

Continued on next page

Prior Approval for Visual Aids, Continued

Contractors

If necessary information is missing from the prior approval form, the contractor will make two attempts to call the provider. If there is no response, the provider's order will be returned for the required information. To expedite the order, all necessary information must be supplied when the prior approval form is sent to EDS. **Enter the provider's telephone number on the prior approval form.** This will help prevent delays in calling for necessary information not present on the form or if further clarification of the request is required by EDS or the contractor.

Checking the Status of Approved Eyeglasses Orders

At the provider's request, the contractor will give a status report on an eyeglass order The provider should call Nash Optical at 1-888-388-1353 to verify receipt of the order if a Medicaid order has been pending for more than **10 working days past the EDS approval date**.

If there is no record of receipt, contact the EDS Prior Approval unit and request a copy of the authorization to be sent to the contractor. The contractor cannot accept a provider's copy or a fax copy. The contractor will only fabricate the prescription from the yellow contractor copy of an EDS copy.

Billing Guidelines for Visual Aids

Visual Aids and Dispensing Codes

When billing visual aids, materials are to be billed at invoice cost and an invoice submitted with the claim.
Refer to *Claims Submission and Billing* for more information.

Contact Lens

Code	Description	Units	Specifications
V0310	Standard hard contact lens, monocular	1	Attach invoice cost
V0300	Standard soft contact lens, monocular lens (1) unit	1	Attach invoice cost
	Note: bill 2 units for binocular lenses	2	
V2599	Contact lens care kit	1	Attach invoice cost

Subnormal Visual Aids

Code	Description	Units	Specifications
V2600	Magnifiers/readers	1	Attach invoice cost
V5516	Telescopic glasses	1	Attach invoice cost
V5517	Microscopic glasses	1	Attach invoice cost
V5518	Loupes	1	Attach invoice cost
V1035	Temporary or loaner cataract glasses to include dispensing	1	$25.00 maximum

Continued on next page

Billing Guidelines for Visual Aids, Continued

Visual Aids and Dispensing Codes (continued)

Provider's Supply of Medicaid Lenses/Frames

Code	Description	Units	Specifications
V0730	Not otherwise classified (frame, lenses, special services)	1	Attach invoice cost
V5534	Supply uncut lenses	1 or 2	Attach invoice cost
Y5535	Edge and mount single vision lenses	1 or 2	
Y5536	Edge and mount multifocal lenses	1 or 2	

Dispensing Codes (including k-reading, measurement fittings, training, etc.)

Code	Description	Units
V0500	Single vision lens	1 or 2
V0290	Bifocal or balance lens	1 or 2
V0640	Trifocal lens	1 or 2
V1110	Cataract lens	1 or 2

Contact Lenses

Code	Description	Units
V0320	Dispense contact lens	1
V0330	Dispense contact lenses	2

Replacement Contact Lenses

Code	Description	Units
Y5513	Dispense new prescription lens for previous contact lens	1
Y5514	Dispense replacement (previous prescription) contact lens to previous contact lens wearer	1
	Note: When dispensing a pair of lenses	2

Telescopic and Microscopic Aids

Code	Description	Units
Y5511	Monocular	1
Y5512	Binocular	1

Frames and Repairs: To Include Adjustments

Code	Description	Units
V0140	Dispense frame	1
V0131	Dispense frame front	1
V2030	Dispense temple (1)	1
	Note: When dispensing a pair of temples	2

Continued on next page

Billing Guidelines for Visual Aids, Continued

Billing for Visual Aids

When billing for a visual aid, the provider is required to enter the diagnosis code in block 21 of the HCFA-1500 claim form. (See *Claims Submission and Billing* for more information.) Diagnosis code 369.9 (unspecified visual loss) or the recipient's refractive diagnosis should be used:

366.0	Cataract	367.3	Anisometropia/Aniseikonia
366.1	Cataract	367.4	Presbyopia
366.2	Cataract	367.5	Disorders or accommodation
366.3	Cataract	367.8	Other disorders of refraction and accommodation
366.4	Cataract		
366.5	After cataract	367.9	Unspecified disorders of refraction and accommodation
366.8	After cataract		
366.9	After cataract	367.9	Unspecified disorders of refraction and accommodation
367.0	Hyperopia		
367.1	Myopia	V72.0	Eye and vision examination
367.2	Astigmatism		Emmetropia (no correction required)

Billing Dispensing Fees for Glasses that Cannot be Dispensed

Providers should make "payment arrangements" with the recipient for noncovered services prior to requesting approval for covered materials from Medicaid. The provider cannot withhold a recipient's glasses paid for by the Medicaid program because the recipient has not paid for the non-Medicaid-covered tint or service. The recipient will not be eligible to receive new lenses from Medicaid again until the time limitation period has expired.

If the recipient fails to respond to verbal and written communications advising him that the glasses are ready for dispensing, the provider may send their dispensing claim and glasses to the EDS Optical Prior Approval Unit. The provider must allow at least three months to lapse after receiving the glasses from the contractor before billing. The provider may then bill the dispensing fee for up to one year from the date of EDS approval. The dispensing claim may be entered for payment if the following conditions are met:

1. Dates of attempts to contact the recipient by telephone are documented.
2. A copy of the final written (letter) attempt to the recipient requesting that they return the visual aids to the provider's office must be attached to the provider's claim.
   For a **deceased recipient**, document the date of death on the claim.

If the required documentation is not received with the glasses, the claim cannot be processed for payment.

If, after the visual aids have been returned to EDS, the recipient returns to the provider requesting the visual aids, the provider must submit a new Request for Prior Approval for Visual Aids form (372-017) for replacement eyeglasses. In block 15 of the request form, document the original EDS approval date, the date the eyeglasses were returned, and state that the original eyeglass were returned due to recipients failure to pickup the eyeglasses.

Visual Field Examinations

Visual Fields

Visual field exams are only covered by Medicaid with specific medical justification. Visual fields are deemed medically necessary in the following circumstances:

- glaucoma
- glaucoma suspect
- visual loss (not including refractive error)
- suspect tumor that may affect vision (such as tumors of the brain or spinal cord)
- large cup/disc ration
- patients on planquenil therapy (used for treatment of malaria, lupus erythematosus, and rheumatoid arthritis)
- any diagnosis that is medically justified regarding visual impairment (i.e., retinopathies, optic nerve disorders)

Punctum Plugs

Punctum Plugs

When billing for punctum plugs, the provider should bill the appropriate surgery code, 68761. This code includes the reimbursement for the plugs. Specify in block 24G on the HCFA-1500 these units: 1 unit = 1 plug, 2 units = 2 plugs.

Billing Guidelines for Cataract Surgery

Use of Modifiers to Bill for Cataract Surgeries

Effective June 25, 1999, claims received from physicians and certain other practitioners will be processed according to guidelines for modifiers. Eye care providers, including ophthalmologists and optometrists are included in this change. Optical suppliers are not affected.

Modifiers 54 and 55 allow a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. Modifier 54 denotes “surgical care only” and is appended to a surgical procedure code if the surgeon agrees to relinquish the postoperative management to another provider. Modifier 55 denotes “postoperative management” only and is appended to a surgical procedure code if a provider other than the surgeon renders postoperative care.

Continued on next page

Billing Guidelines for Cataract Surgery, Continued

Use of Modifiers to Bill for Cataract Surgeries (continued)

Prior to the implementation of modifiers, ophthalmologists who performed only the surgical part of cataract surgery billed the following codes when submitting claims

W9931	Intracapsular cataract extraction with insertion of lens prosthesis (no follow-up care).
W9941	Extracapsular cataract extraction with insertion of lens prosthesis (no follow-up care).
W9951	Insertion of intraocular lens subsequent to cataract removal.

Effective for claims submitted on or after June 25, 1999, "W" codes **must** be replaced with the appropriate CPT procedure code for cataract surgery – 66983, 66984 or 66985 – and appended with modifier 54.

Currently, ophthalmologists or optometrists who render postoperative care following cataract surgery bill the following codes:

Y5575	Follow-up care for codes W9931, W9941 or W9951 (one eye)
Y5576	Follow-up care for codes W9931, W9941 or W9951 (two eyes)

Effective for claims submitted on or after June 25, 1999, "Y" codes **must** be replaced with the appropriate CPT procedure code for cataract surgery – 66983, 66984 or 66985 – and appended with modifier 55.

Note: These procedure codes must be billed with a diagnosis code of V43.1 or 379.31.

Refer to *Claims Submission and Billing* for more information.

Examples of Billing with Modifiers

Example I: Surgery and Preoperative Care Only

- The ophthalmologist performs procedure 66984.
- **All** postoperative care is transferred to another provider.
- The ophthalmologist who performs the surgery will enter 66984-54 on the claim.

Continued on next page

Billing Guidelines for Cataract Surgery, Continued

Examples of Billing with Modifiers (continued)

Example II: Provider (Other than Surgeon) Renders ALL Postoperative Care Following Surgery

- The optometrist provides **all** follow-up care to the patient who has had cataract surgery (CPT 66984).
- The optometrist submits a claim entering the surgical procedure codes 66984-55 with the same date of service (date of surgery) and place of service as surgeon.
- Dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in block 16 on the HCFA-1500 claim form or in the designated field for tape or ECS formats.

Example III: Ophthalmologist Provides Initial Postoperative Care and Then Transfers Remainder of Care to Another Provider

- The ophthalmologist performs cataract surgery and enters surgical procedure code 66985-54 on the first detail line of the claim form.
- On the second detail, the provider enters 66985-55 with the same date of surgery and place of service as on the first detail.
- Dates the provider is responsible for postoperative care must be entered in the FROM and TO dates in block 16 on the HCFA-1500 claim or in the designated field for tape or ECS format.

Note: The provider who has accepted responsibility for the remainder of postoperative days (ophthalmologist or optometrist) will also bill the surgical procedure code with modifier 55; in the above example, 66985-55.

Example IV: Ophthalmologist Performs Surgery and All Postoperative Care

- The ophthalmologist performs cataract surgery, CPT procedure code 66983.
- Procedure code 66983 is entered on the claim without either modifier 54 or 55.

Note: When cataract surgery is performed on both eyes at the same time, modifier 50, which denotes a bilateral procedure, must be added to the surgical procedure code along with either modifier 54 or 55.

Billing Restrictions

Reimbursements for codes billed with modifier 54 and 55 is based on the Federal Register Percentage Table. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care rendered by more than one physician, regardless of the number of physicians, cannot exceed the amount allowable if all services were rendered by one physician.

When a recipient is covered by both Medicare and Medicaid, the provider should continue to follow Medicare billing guidelines. Medicaid will continue to pay coinsurance and deductible.

Covered and Noncovered Services

Procedures Covered by Medicaid for Optometrists

In compliance with a mutual agreement between the N.C. Board of Medical Examiners and the N.C. Board of Optometry, the following procedures are covered for payment by DMA for optometrists:

16000	76511	92012	92283	97112	99201	99222	99251	99274	99322
16020	76512	92014	93384	97114	99202	99223	99252	99275	99323
65205	76513	92015	92531	97145	99203	99231	99253	99281	99331
65210	76516	92020	92532	99050	99204	99232	99254	99282	99332
65220	76519	92060	92534	99052	99205	99233	99255	99283	99333
65222	76529	92070	92542	99054	99211	99238	99261	99284	99341
65430	82948	92081	92950	99058	99212	99241	99262	99285	99342
67820	87205	92082	95060	99070	99213	99242	99263	99311	99343
67938	87206	92083	95933	99082	99214	99243	99271	99312	99351
68040	87210	92270	97010	99150	99215	99244	99272	99313	99352
68761	92002	92275	97110	99151	99221	99245	99273	99321	99353
68800	92004	92280							

The following codes are billable by the optometrist only with modifier 55:

66983
66984
66985

Procedures Not Covered by Medicaid for Optometrists

The following procedures are not covered in the practice optometry:

10160	11900	17200	65435	67840	68820	92235	92543	95056	95882
11050	11901	17201	65436	67850	76536	92265	92544	95857	97024
11051	17000	17250	67700	68020	90782	92533	95040	95858	99025
11052	17110	36415	67825	68200	90788	92541	95050	95881	99178

MAIL TO: EDS
P.O. BOX 31188
RALEIGH, N.C. 27622

REQUEST FOR PRIOR APPROVAL

NORTH CAROLINA MEDICAID PROGRAM

1. PRIOR AUTHORIZATION NUMBER

3. MEDICAID IDENTIFICATION NUMBER

PATIENT NAME (LAST) (FIRST) (M.I.)
2.

DATE OF BIRTH
4. MO. DAY YEAR

5. DIAGNOSIS:

ICD 9TH EDITION
6.

(✓) TYPE OF REQUEST

	01	SURGICAL TRANSPLANT
	02	HOSPITALIZATION FOR: DENTAL EXTRACTION
	03	COSMETIC SURGERY
	04	HEARING AID
	05	

7. BRIEF SUMMARY OF CLINICAL FINDINGS:

RETROACTIVE DATE(S) REQUESTED

FROM: MO. DA. YR. 8.

TO: MO. DA. YR. 9.

10. PROCEDURE TO BE PERFORMED

PROCEDURE CODE 11.

12. REASON PROCEDURE IS NECESSARY TO PATIENT'S HEALTH:

13. HAS PATIENT BEEN PREVIOUSLY PROVIDED WITH THIS SERVICE? _____ YES _____ NO

(a) IF YES, GIVE DATE PREVIOUS SERVICE RENDERED AND _____

(b) GIVE DATES OF ANY PREVIOUS PRIOR APPROVAL(S) GRANTED _____

14. PHYSICIAN OR DENTIST
HEARING AID DEALER
OPTOMETRIST _____ 16. DATE _____
SIGNATURE

15. PROVIDER'S NUMBER

17. PLACE OF SERVICE (SEE OTHER SIDE FOR CODE)

EDS USE ONLY

(✓)		
	01	APPROVAL
(✓)		
	02	DENIED

REVIEWED BY _____ DATE _____

COMMENTS

APPROVAL CONSTITUTES MEDICAL APPROVAL FOR SERVICES ONLY. ELIGIBILITY FOR CARE ON THE DATE(S) THE SERVICES ARE PROVIDED SHOULD BE VERIFIED FROM THE PATIENT'S MEDICAID CARD.

18. TYPE, PRINT OR STAMP

NAME

STREET

CITY (STATE) (ZIP CODE)

INDICATE:

PROVIDER'S NAME AND MAILING ADDRESS TO ENSURE RETURN OF THIS FORM.

372-118

EDS COPY

REQUEST FOR PRIOR APPROVAL FOR VISUAL AIDS

APPROVAL CONSTITUTES MEDICAL APPROVAL FOR SERVICES ONLY. ELIGIBILITY FOR CARE IN THE MONTH IN WHICH SERVICES ARE PROVIDED SHOULD BE VERIFIED FROM PATIENT'S MEDICAID CARD.

PLEASE TYPE OR PRINT — SEE INSTRUCTIONS ON BACK OF FORM

1. PATIENT NAME - LAST	2. FIRST	3. MI	4. SEX M 1 F 2	5. MEDICAID I.D. NUMBER

6. ACTION (FOR DEPT. USE ONLY)	7. PRIOR AUTHORIZATION NUMBER	8. DATE OF BIRTH MO DAY YR	9. CHILD SCREEN IHS REFERRAL YES 1 NO 2	10. DIAGNOSIS	
BY				11. DATE OF REFRACTION	12. NAME OF PRESCRIBER
DATE					

13. AUTHORIZATION REQUESTED FOR:

* SERVICES REQUIRE DOCUMENTATION OF MEDICAL NECESSITY.

- ☐ BIFOCAL LENSES (CIRCLE ONE) CFR ST-22 ST-25 ST-28 * ST-35 * EXECUTIVE
- ☐ * TRIFOCAL
- ☐ REPAIR
- ☐ ZYLONITE FRAME
- ☐ SINGLE VISION LENSES
- ☐ CATARACT LENSES
- ☐ * CONTACT LENSES
- ☐ REPLACEMENT
- ☐ * COMBINATION
- ☐ * PINK TINT 1 2
- ☐ * OVERSIZE
- ☐ * OTHER (SPECIFY BELOW)

14. LAST PRESCRIPTION

	Sphere	Cyl.	Axis
Rt.			
Lt.			
Rt.			
Lt.			

DATE OF LAST CHANGE:

15. PROVIDER DOCUMENTATION/JUSTIFICATION FOR APPROVAL OF ABOVE
* PROCEDURES AND REQUESTS FOR EXCEPTIONAL SERVICES

16. PLEASE CIRCLE ONE	SUPPLY FRAME	FRAME ENCLOSED	FRAME TO FOLLOW	LENSES ONLY

FRAME NAME	EYE	BRIDGE	TEMPLE

COLOR	ALTERNATE COLOR

FT. 25	FT. 35	Exec. Bif.	Cataract — Specify Type	Plastic	
FT. 28	RD. Seg	Tri. 7 x 25	Tri. 7 x 28	Glass	

	Sphere	CYL	Axis	Prism	Base	Decenter In	Decenter Out
R							
L							

	Segment Height	Segment Inset	Total Inset	Pupillary Distance Far	Pupillary Distance Near
ADD R					
ADD L					

17. PROVIDER AUTHORIZATION TO THE CONTRACTOR TO SUPPLY THE FOLLOWING SERVICES. THESE SERVICES WILL BE BILLED TO THE PROVIDER'S PERSONAL ACCOUNT BY THE CONTRACTOR. DO NOT REQUEST SERVICES THE CONTRACTOR IS NOT AUTHORIZED TO SUPPLY.

- ☐ EDGE LENSES - ZYLONITE FRAME
- ☐ EDGE LENSES - METAL FRAME
- ☐ TINT: _____
- CIRCLE LENS TYPE: SV CFR EXECUTIVE ST 25 28 35 TRIFOCAL
- ☐ UV ☐ HARD COTE

PROVIDER SIGNATURE

SPECIAL INSTRUCTIONS TO CONTRACTOR

18. TYPE, PRINT OR STAMP ALL COPIES — PROVIDER NUMBER

NAME

STREET

CITY (STATE) (ZIP CODE)

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAW.

19. (SIGNED) _____

20. BILL DATE MO. DAY YR

TELEPHONE NO.

372-017 (12/95)